

STUDENT NAME: \_\_\_\_\_ Birthdate: \_\_\_\_\_

**IMMUNIZATIONS:** The following Immunizations are the MINIMUM required for acceptance into the AFICE program. Depending on a particular State or School, additional vaccines may be required. The student will be fully responsible for paying out of pocket for any additional immunizations that are required, and will not be considered or accepted onto the AFICE program without the completed requirements as listed here at the time of application to the AFICE program. Physician must list the age of student at time of vaccine.

**POLIO** – 3 doses required if 3<sup>rd</sup> dose was administered on or after 4<sup>th</sup> birthday – otherwise 4<sup>th</sup> dose required

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Age \_\_\_\_      \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Age \_\_\_\_      \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Age \_\_\_\_      \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Age \_\_\_\_

**DTP – (Diphtheria, Tetanus, Pertussis)** – 4 doses required if at least 1 dose was administered after the age of 4. Additional dose will be required if last vaccine was administered on or after 2<sup>nd</sup> birthday

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Age \_\_\_\_      \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Age \_\_\_\_      \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Age \_\_\_\_      \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Age \_\_\_\_

**Tdap Booster** (Tetanus, reduced diphtheria and pertussis) – 1 dose administered after age 13

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Age \_\_\_\_

**MENINGOCOCCAL** – 1 dose required between the ages of 13 – 17

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Age \_\_\_\_

**HEPATITIS B**

3 doses required

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Age \_\_\_\_      \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Age \_\_\_\_      \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Age \_\_\_\_

**MEASLES (Rubeola)** – 2 doses required, beginning on or after 1<sup>st</sup> birthday (part of MMR Vaccine)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Age \_\_\_\_      \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Age \_\_\_\_      Or, Date of Disease: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Age \_\_\_\_

**MUMPS** – 2 doses required, beginning on or after 1<sup>st</sup> birthday (part of MMR Vaccine)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Age \_\_\_\_      \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Age \_\_\_\_      Or, Date of Disease: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Age \_\_\_\_

**RUEBELLA** – 2 doses required, beginning on or after 1<sup>st</sup> birthday (part of MMR Vaccine)

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Age \_\_\_\_      \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Age \_\_\_\_      Or, Date of Disease: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Age \_\_\_\_

**VARICELLA (Chicken Pox)** – 1 dose minimum required – 2<sup>nd</sup> dose required between the ages of 13-17

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Age \_\_\_\_      \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Age \_\_\_\_      Or, Date of Disease: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Age \_\_\_\_

**TB TEST**

Results: + / -      Date: \_\_\_\_\_      Results: \_\_\_\_\_  
(Circle One)      Month / Day / Year

Has the student ever had a BCG vaccine for Tuberculosis? Yes \_\_\_\_\_ Date: \_\_\_\_\_ No \_\_\_\_\_  
Month / Day / Year

Has the student ever had a chest X-ray? Yes \_\_\_\_\_ Date: \_\_\_\_\_ No \_\_\_\_\_ Result: \_\_\_\_\_  
Month / Day / Year

**WE HEREBY CERTIFY THAT THE INFORMATION GIVEN IN THIS IMMUNIZATION CERTIFICATE IS COMPLETE AND ACCURATE TO THE BEST OF OUR KNOWLEDGE AND BELIEF**

\_\_\_\_\_  
Signature of Physician      Name of Physician (print or type)      \_\_\_\_/\_\_\_\_/\_\_\_\_  
Month      Day      Year

\_\_\_\_\_  
Address of Physician's office or clinic